Summary of Benefits

ALERT! Even if a provider orders a test or prescribes a treatment, the plan may not cover it. Please review this *Certificate of Coverage* or call Customer Service at 1-888-849-3681 if you have questions about benefits or limitations.

On the next several pages, you'll find a summary of your plan benefits, a convenient reference to help you find the information you need. For a complete understanding of how a benefit works, it is important that you also read the pages listed in the "For More Information" column.

Not all benefits are listed. For services not listed, see the Table of Contents or call UMP Customer Service at 1-888-849-3681.

In order to be covered, all services must be medically necessary (see the definition on pages 212–214).

If you see an unfamiliar term, see the alphabetical list of definitions on pages 201–226.

This Certificate of Coverage applies only to dates of service between the day your coverage begins (but no earlier than January 1, 2016) and the day your coverage ends (but no later than December 31, 2016).

ALERT! If you have coverage under another health plan, see pages 123–132. If your other coverage is Medicare, see pages 133–143.

Deductibles and Limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Medical deductible	$250 per person (maximum of $750 for a family of three or more) See page 21 if you qualified for the 2016 SmartHealth $125 wellness incentive.	▪ You pay toward the medical deductible before the plan pays for covered medical services. ▪ You don't have to pay the medical deductible for some services. ▪ Not all services count toward this deductible.	22–24
Prescription drug deductible	$100 per person (maximum of $300 for a family of three or more)	▪ You pay the costs for Tier 2 and Tier 3 drugs until you reach this amount. ▪ The plan pays its share for Value Tier and Tier 1 drugs right away; you don't pay the deductible.	87–88
Medical out-of-pocket limit	$2,000 per person (maximum of $4,000 for a family of two or more) For Medicare-primary members: $2,500/$5,000	Your medical deductible and all coinsurance and copays for covered in-network services count toward this limit.	26–28
Prescription drug out-of-pocket limit	$2,000 per person (no family maximum)	Your prescription drug deductible and coinsurance count toward this limit; see page 89 for details.	89
Annual plan payment limit	None	No limit to how much the plan pays per calendar year.	Not applicable
Lifetime plan payment limit	None	No limit to how much the plan pays over a lifetime.	Not applicable

How Much Will I Pay?

The table below describes how much you'll pay for services. Unless otherwise noted, all payment is based on the allowed amount, which is the fee accepted as payment by a preferred provider, and services are subject to the medical deductible. See the Summary of Benefits table on pages 33–42 for which type of service applies to a specific benefit.

Type of Service	How Much You Pay
Standard **Subject to the medical deductible:** You must pay the first $250 in covered services before the plan begins to pay.	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred providers**—You pay 15% of the allowed amount. ▪ **Out-of-network providers**—You pay 40% of the allowed amount; the provider may balance bill (see page 203). ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill. Indicated by $$ in the provider directory on **regence.com**.
Preventive Preventive services **are not subject to the medical deductible** (you don't have to pay your deductible before the plan pays).	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred and participating providers**—You pay $0: the plan pays in full. ▪ **Out-of-network providers**—You pay 40%; the provider may balance bill.
Outpatient Subject to the medical deductible.	If you receive services at a facility that offers inpatient services but you are not admitted as an inpatient, the services are covered as outpatient. See the specific benefit—for example, diagnostic tests—for how much you will pay.

Type of Service	How Much You Pay
Inpatient **Subject to the medical deductible.** You pay the inpatient copay and separate charges for professional services, such as doctor consultations and lab tests. See the specific benefit—for example, diagnostic tests—for how the plan covers these related services. ▪ Professional providers may contract separately from a facility. Even if a facility is preferred, a professional provider may not be. ▪ Most inpatient services require both: ◆ **Preauthorization:** See page 111 for a description of how this works. ◆ **Notification:** Your provider must notify the plan upon admission to a facility; see page 112 for a description of how this works.	The inpatient copay is $200 per day at preferred facilities. ▪ Employees and retirees not enrolled in Medicare: $600 maximum per calendar year. ▪ Retirees enrolled in Medicare: $600 maximum per admission up to the medical out-of-pocket limit. Note: The inpatient copay counts toward your medical out-of-pocket limit. When you are admitted to a preferred facility as an inpatient, you will pay: ▪ Any remaining medical deductible; ▪ The inpatient copay; AND ▪ Your coinsurance for professional services; depends on the provider's network status as described under the Standard type of service, listed above. If you receive non-emergency inpatient care at an out-of-network facility, you will pay according to the Standard benefit above. See page 15 and page 19 for details of coverage of out-of-network facility charges. Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of "Inpatient Stay" on page 210.
Special Subject to the medical deductible.	These services have unique payment rules, which are described in the "How much will I pay?" column on pages 33–42.

What else do I need to know?

- Some services aren't covered; see pages 116–122 for some of the services not covered by the plan.
- You don't need a referral from the plan to see a specialist for most services. However, you will save money by seeing preferred providers, especially for preventive services; see page 14.
- Preexisting conditions: There is no waiting period; medically necessary covered services are eligible for benefits from the effective date of your medical enrollment.

Summary of Benefits

Only certain services are listed in the table. For those not listed, see the alphabetical list of covered benefits on pages 43–83 or call Customer Service at 1-888-849-3681.

Please read the pages listed in the "For more information" column for each benefit. Not all details are included in the table. We recommend that you also review:

- Services that require preauthorization (see page 111 for how this works); see page 112 for how to find the current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services for which your provider must notify the plan; see the current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services that aren't covered (exclusions); see pages 116–122.

If you have questions about services that require preauthorization or plan notification, or services not covered by the plan, call Customer Service at 1-888-849-3681.

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Ambulance	**Special:** 20% of the allowed amount for preferred or out-of-network providers. Out-of-network providers may balance bill.	45, 116, 121	Covered only for a medical emergency (see definition on page 212).
Applied Behavior Analysis (ABA) Therapy	Standard	46	Specific preauthorization requirements; see page 46. Only specified providers are covered; see page 46.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Chemical Dependency Treatment			
Inpatient Services	Inpatient	48, 120, 138	See page 48 for preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	48, 120, 138	See page 48 for services that may require preauthorization.* May be subject to review for medical necessity.
Chiropractic Physician Services		76	See "*Spinal and Extremity Manipulations"* on page 40.
Contraceptive Services for Women	Preventive or Standard	58–61, 73	See page 59 for services that are covered as preventive. Some contraceptive services may be covered as Standard.
Dental Services	**Special:** You pay 20% of the allowed amount. No preferred dentists; providers may balance bill (see definition on page 203)	50, 117	See "Dental Services" on page 50 for limitations on covered services.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Diabetes Care Supplies	**Special:** Paid under the prescription drug benefit; see pages at right.	52, 130, 137	See page 137 if Medicare is your primary coverage.
Diabetes Control Program: NOT ME	Preventive	53	Only the NOT ME program is covered.
Diabetes Prevention Program: NOT ME	Preventive	53	Only the NOT ME program is covered.
Diagnostic Tests, Laboratory, and X-Rays	Standard	54, 71, 116, 119, 122	Usually billed separately from related office visits or inpatient services.
Durable Medical Equipment, Supplies, and Prostheses	Standard	55–57, 82, 96, 117, 120, 205	May require preauthorization.* Some breast pumps are covered as preventive; see "Services Covered as Preventive" on page 70.
Emergency Room (ER) *You pay a $75 copay per visit (in addition to coinsurance)*	Standard plus the ER copay ($75) You are usually billed separately for: ▪ Facility charges ▪ Professional (physician) services ▪ Lab tests, x-rays, and other imaging tests	58, 212	If you are admitted as an inpatient directly from the ER, you won't owe the ER copay (but will pay the inpatient copay). Services determined not to be due to a medical emergency (page 212) are not covered in an emergency room setting.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
End-of-Life Counseling	▪ If received as part of hospice: Paid at 100% after meeting medical deductible. ▪ If received outside of hospice services: Standard.	58	Total of 30 visits, all services combined.
Family Planning Services	Standard *Some contraceptive services are covered as preventive; see page 59.*	58–61, 118	Not covered: ▪ Infertility services ▪ Reversal of sterilization
Hearing Aids Not subject to medical deductible	**Special:** Plan pays up to $800.	62, 137	Limited to $800 plan payment per three calendar years.
Hearing Exams, Routine	Preventive	62, 73, 137	One per calendar year.
Home Health Care	Standard	63, 78, 118, 204, 209, 211	See page 63 for what is covered. Specific services are not covered; see exclusion 24 on page 118. Maintenance care (page 211) and custodial care (page 204) are not covered.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Hospice Care (Includes respite care)	**Special:** Paid at 100% after meeting medical deductible.	63, 209, 224	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime.
Hospital Services			
Inpatient Services	Inpatient	64, 69–71, 118, 138	All elective inpatient admissions (except maternity) require preauthorization.* Plan notification is required for all hospital admissions within 24 hours of admission.* Inpatient rehabilitation services require preauthorization.*
Outpatient Services	Standard	64	Some services require preauthorization.*
Immunizations (Vaccines)	Preventive (usually)	75, 118, 215	Covered under CDC recommendations; see page 75. *Not covered for travel or employment.*

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Mammograms (Diagnostic)	Standard	66	Must be billed as diagnostic by the provider.
Mammograms (Screening) *See "Breast Health Screening Tests" on page 47 for additional services covered.*	Preventive	47, 66	**Women age 40 and older:** Covered every one to two years. **Women under age 40:** Covered as preventive only for women at increased risk; see page 66 for details. For women under age 40 and not at increased risk, see page 66. *See "Breast Health Screening Tests" on page 47 for additional services covered.*
Massage Therapy	Standard	67, 119	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
Mastectomy and Breast Reconstruction	Inpatient (Standard for related outpatient visits)	55, 67	All inpatient services require plan notification.*

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Mental Health Treatment			
Inpatient Services	Inpatient	67, 120, 138	See page 67 about preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	67, 119, 120, 138	See page 67 for services that require plan notification.*
Naturopathic Physician Services	Standard	19, 68, 108, 117, 137	Herbs, vitamins, and other supplements are not covered. See "Exceptions Covered" on page 105 for exceptions.
Obstetric and Newborn Care	Inpatient (Standard for related outpatient visits) *Some breast pumps are covered as preventive; see page 70.*	69–71, 122	For non-routine services for a newborn, you may pay toward the baby's medical deductible or inpatient copay; see page 69. See page 69 for coverage of circumcision for males, which is not a preventive service.
Office Visits	Standard	72, 119	See pages 73–75 for routine exams covered as preventive.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Physical, Occupational, Speech, and Neurodevelopmental Therapy	Standard *Charges for inpatient services are not included in the inpatient copay.*	72, 119, 211	**Inpatient:** 60 days maximum per calendar year. **Outpatient:** 60 visits maximum per calendar year.
Prescription Drugs	See "Your Prescription Drug Benefit" on pages 84–110.		See exclusions on pages 116–122, and other limits on pages 98–102.
Preventive Care Includes vaccines, routine exams, some screening tests	Preventive	66, 70, 73–75, 106, 137, 221	Only certain services are covered as preventive; see pages 73–75. See page 70 for contraception covered as preventive.
Skilled Nursing Facility	Inpatient *Some services may be billed separately (such as physical therapy).*	76, 119, 121, 224	Maintenance care (page 211) and custodial care (page 204) are not covered.
Spinal and Extremity Manipulations	Standard	76, 119	Limited to 10 visits per calendar year.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Surgery		51, 64, 67, 72, 77, 81, 118, 122, 202, 216, 223	Bariatric surgery: page 47. Transgender surgery: page 81.
Inpatient Services	Inpatient		Some services require preauthorization and/or plan notification.*
Outpatient Services	Standard		Some services require preauthorization.*
Telemedicine Services	Standard	78	
Tobacco Cessation Services	Preventive	78	See page 78 for coverage of drugs and nicotine replacement supplies. See page 80 for tobacco cessation services for members ages 17 and under.
Transgender Services	Standard	81	Some services require preauthorization and/or plan notification. See page 81 for covered services.
Urgent Care You don't pay the ER copay for urgent care services.	Standard	81	

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*

Benefit/Service	How much will I pay? (See pages 31–32 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Vision Care (Related to Diseases and Disorders of the Eye)	Standard	82, 116, 118, 119	
Vision Exams, Routine	Preventive	82, 118, 119	One per calendar year. The plan pays up to $65 per year for contact lens fitting fees; you pay any additional charges.
Vision Hardware, Adults (Over age 18) Glasses, contact lenses	**Special:** You pay any amount over $150; network status of provider does not matter. No medical deductible.	82	Plan pays up to $150 per two calendar years (resets every even year).
Vision Hardware, Children (Age 18 and under) Glasses, contact lenses	**Special:** No medical deductible. **Eyeglasses:** You pay $0 for one set of standard or deluxe frames and lenses per year. **Contact lenses:** You pay 15% of billed charges.	83	Plan pays for one pair of eyeglasses per year at 100% of billed charges. See page 83 for options that aren't covered. No limit on number of contact lenses covered.
Well-Child Visits	Preventive	73–75	See pages 73–75.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 111–113 for how this works.*